Confidential Medical History & Review of Systems

Patient Name: _____ **Date of Birth:** _____
Date: _____
Height: _____ **Weight:** _____**lbs.** **Family Doctor:** _____
(We are required by insurance companies to collect this data)

Family History

Please answer the questions below regarding your **immediate family** (parents, grandparents, siblings, children).
For all "YES" answers please specify family member.

Blindness/Vision Loss	Yes / No _____	Diabetes	Yes / No _____
Crossed or "Lazy" eye	Yes / No _____	High Blood Pressure	Yes / No _____
Cataracts	Yes / No _____	High Cholesterol	Yes / No _____
Glaucoma	Yes / No _____	Heart Disease	Yes / No _____
Macular Degeneration	Yes / No _____	Lupus	Yes / No _____
Retinal Degeneration	Yes / No _____	Thyroid Disease	Yes / No _____
Other Eye Disease		Cancer _____	Yes / No _____
_____	Yes / No _____	Other _____	Yes / No _____

Review Of Systems

Do **YOU** currently have any problems in the following areas:

Eyes		**Ears/ Nose/Throat**		**Neurological**	
Blindness	Yes/No	Allergies/Hay fever	Yes/No	Headaches (Chronic)	Yes/No
Blurred Vision	Yes/No	Sinus Congestion	Yes/No	Migraines	Yes/No
Crossed or "Lazy" eyes	Yes/No	Dry Throat/Mouth	Yes/No	Seizures	Yes/No
Cataracts	Yes/No	**Respiratory**			
Glaucoma	Yes/No	Asthma	Yes/No		
Macular Degeneration	Yes/No	Emphysema	Yes/No	**Current Medications**	
Retinal Detachment	Yes/No	Chronic Bronchitis	Yes/No	_____	
Eye Trauma or Injury	Yes/No	**Vascular/Cardiovascular**		_____	
Distorted vision/halos	Yes/No	Diabetes	Yes/No	_____	
Loss of side vision	Yes/No	Vascular Disease	Yes/No	_____	
Double Vision	Yes/No	High Cholesterol	Yes/No		
Dryness	Yes/No	High blood pressure	Yes/No		
Mucous Discharge	Yes/No	**Gastrointestinal**		**Have you had eye surgery?**	
Redness	Yes/No	Chronic Diarrhea	Yes/No	Lasik	Yes/No
Sandy or Gritty eyes	Yes/No	**Genitourinary**		PRK	Yes/No
Itching	Yes/No	Kidney/bladder	Yes/No	RK	Yes/No
Burning	Yes/No	**Bones/Joints/Muscles**		Cataract	Yes/No
Glare/Light Sensitivity	Yes/No	Rheumatoid Arthritis	Yes/No		
Eye pain or soreness	Yes/No	**Lymphatic/Hematologic**		**Social History**	
Flashes	Yes/No	Anemia	Yes/No	Do you smoke?	Yes/No/Quit
Floaters	Yes/No	Bleeding Problems	Yes/No	Alcohol misuse?	Yes/No/Quit
Constitutional		**Endocrine**			
Fever/Weight Changes	Yes/No	Thyroid	Yes/No	**Allergies to Medications**	
Integumentary (Skin)		**Psychiatric**		_____	
Rosacea	Yes/No	Depression	Yes/No	_____	
Other:_____	Yes/No				

Other condition not listed above:

_____

Patient Signature: _____ **Date:** _____